

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04454

4508

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Washington</u>	MARYLAND	STATE <u>PA.</u>	COUNTY <u>Franklin Co.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport</u>	LENGTH OF STAY (in this place) <u>22 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Waynesboro, Rt. 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanitarium</u> <u>154 N. Artizan St.</u>		STREET ADDRESS (If rural give location) <u>75X-3</u>	
3. NAME OF DECEASED (Type or Print) <u>Helen</u> (First) <u>M.</u> (Middle) <u>Alexander.</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>20</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>March 5, 1871</u>
9. AGE last birthday <u>85</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>0</u> (Days) <u>0</u> IF UNDER 24 HRS. (Hours) <u>0</u> (Min.) <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Tilman Norris</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Mentzer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>Mrs. David Fleagle</u> <u>Arnold, Md. - Rt. 1</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
332X IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u>			<u>48 hrs.</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Cerebral thrombosis</u>			<u>5-10 yrs.</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1722</u> to <u>1956</u> , to <u>April 20</u> , 1956, that I last saw the deceased alive on <u>April 20</u> , 1956, and that death occurred at <u>8:40</u> P.M. from the causes and on the date stated above.			
SIGNATURE <u>Edward W. Dwyer</u>		DATE SIGNED <u>4/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. DATE BY REGISTRAR <u>APR 25 1956</u>	
25. NAME OF CEMETERY OR CREMATORY <u>United Brethren Cem.</u>		26. LOCATION (City, town, or county) <u>Thurmont Fredk. Co Md</u>	
27. REGISTRAR'S SIGNATURE <u>E. S. McElroy</u>		28. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Weaver</u>	
29. ADDRESS <u>Thurmont</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. DEATH INFORMATION (NAME OF DECEASED)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. TIME OF BIRTH

12. PLACE OF DEATH

13. DATE OF DEATH

14. TIME OF DEATH

15. PLACE OF BIRTH

16. DATE OF BIRTH

17. TIME OF BIRTH

18. PLACE OF DEATH

19. DATE OF DEATH

20. TIME OF DEATH

21. PLACE OF BIRTH

22. DATE OF BIRTH

23. TIME OF BIRTH

24. PLACE OF DEATH

25. DATE OF DEATH

26. TIME OF DEATH

27. PLACE OF BIRTH

28. DATE OF BIRTH

29. TIME OF BIRTH

30. PLACE OF DEATH

31. DATE OF DEATH

32. TIME OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. TIME OF BIRTH

36. PLACE OF DEATH

37. DATE OF DEATH

38. TIME OF DEATH

39. PLACE OF BIRTH

40. DATE OF BIRTH

41. TIME OF BIRTH

42. PLACE OF DEATH

43. DATE OF DEATH

44. TIME OF DEATH

45. PLACE OF BIRTH

46. DATE OF BIRTH

47. TIME OF BIRTH

48. PLACE OF DEATH

49. DATE OF DEATH

50. TIME OF DEATH

Initial

4-23-1926

United Western Corp. Investment

Wash. D.C.

BUREAU V. 3

RECEIVED

CERTIFICATE OF DEATH

04455

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>EUGENE</u> Last <u>BAIR</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 13, 1927</u>
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vending Machine</u>	11. BIRTHPLACE (State or foreign country) <u>Washington Co Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Russell T Bair</u>		14. MOTHER'S MAIDEN NAME <u>May Hoffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>World War II 214-28-0075</u>	
17. INFORMANT <u>R.T. Bair</u>		Address <u>1770 Jefferson Blvd Hagerstown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic carditis and myocarditis</u> DUE TO 401.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic fever</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 weeks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>April 17</u> , 19 <u>56</u> , to <u>April 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>56</u> , and that death occurred at <u>3:30P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		ADDRESS (Street, city or town, state) <u>148 W. Washington St.</u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		DATE SIGNED <u>4/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>
22d. LOCATION (City, town, or county) <u>Hagerstown Md.</u>		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel, Inc.</u>		ADDRESS <u>Wm. A. Horst V Pres.</u>	
24a. REC'D BY REGISTRAR <u>Apr. 24, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Washington County Hospital		Date	
1951 October 24		1951	
Hickory Ridge		Race	
White Male		Age	
1927		1951	
Washington County Hospital		Cause of Death	
1951		1951	

BUREAU V. A.

APR 26 1956

RECEIVED

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4460

CERTIFICATE OF DEATH

04456

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY WASHINGTON		MARYLAND		STATE MARYLAND		COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAGERSTOWN		LENGTH OF STAY (in this place) 28 YRS 3 4		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL				STREET ADDRESS (If rural give location) 805 FREDERICK ST.			
3. NAME OF DECEASED (Type or Print) (First) EARL (Middle) SHIFFLER (Last) BAKER				4. DATE OF DEATH (Month) APRIL (Day) 3 (Year) 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 11/23/1888	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK		10b. KIND OF BUSINESS OR INDUSTRY POST OFFICE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES S. BAKER				14. MOTHER'S MAIDEN NAME FANNIE SHIFFLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS. BEULAH K. BAKER		HAGERSTOWN MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 421.1 Congestive Cardiac Failure						INTERVAL BETWEEN ONSET AND DEATH 8 weeks	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease with Myocardial Infarction						14 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Calcific Aortic Stenosis						20-40 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. at work) (Not while at work)		21e. INJURY OCCURRED While at work () Not while at work ()		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-5-46., 19....., to 4-3....., 19..56., that I last saw the deceased alive on 4-3....., 19..56., and that death occurred at 4:15AM, from the causes and on the date stated above.							
SIGNATURE <i>Salton M. Welty</i>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4/5/56		NAME OF CEMETERY OR CREMATORY BEAVER CREEK CEM.		LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
24. REC'D BY REGISTRAR DATE Apr. 6, 1956		REGISTRAR'S SIGNATURE <i>Chas. H. Bowers</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Normant</i> ADDRESS <i>Hagerstown, Md.</i>			

5.

RECEIVED

BUREAU V. S.

APR 9 1956

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4461
CERTIFICATE OF DEATH

04457

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 25 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 Bower Ave.		d. STREET ADDRESS 122 Bower Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUSSEL Middle SAMUEL Last BATES		4. DATE OF DEATH Month April Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 2 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Herald-Mail	
11. BIRTHPLACE (State or foreign country) Stephens City, Vir.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Bates		14. MOTHER'S MAIDEN NAME Mary Congill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-16-0568	
17. INFORMANT Mrs. Rose Bates		122 Bower Ave Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-1- , 19 56 , to 4-27- , 19 56 , that I last saw the deceased alive on 4-24- , 19 56 , and that death occurred at 9:15 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE D. E. Williams		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 4/27/56	
PHYSICIAN'S NAME (Type) Dr. E. W. Dittus			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 29, '56	
22c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		22d. LOCATION (City, town, or county) (State) Stephens City, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Leaf		ADDRESS Williamsport, Md.	
24a. REC'D BY REGISTRAR Apr. 28, 1956		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

10-20-87

Legend:

STANLEY

• VINOJ CR-201

153 POWER, Vol. 4

135 Bowdoin Ave.

520

0681, #S. (1)

2007-01-10 10:00:00

11-5-1958

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17-05-05

BUREAU V. S.

MAY 1 1956

RECEIVED

4462

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>5 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>81 WASH. CO. HOSPITAL</u>		d. STREET ADDRESS <u>MAPLE AVENUE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANNIE VIRGINIA BLUBAUGH</u>		4. DATE OF DEATH Month Day Year <u>APRIL - 11 - 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE - 21 - 1898</u>
9. AGE (In years last birthday) <u>57-9-26</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>SHARPSBURG WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD L. CLIPP</u>		14. MOTHER'S MAIDEN NAME <u>LAURA GEASLIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>BRUCE B. BLUBAUGH</u>		Address <u>BOONSBORO MD. R. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension Vas. Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>yo.</u> <u>yo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 11</u> , 19 <u>56</u> , to <u>Apr 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr 11</u> , 19 <u>56</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis G. Graff</u> M.D.		ADDRESS (Street, city or town, state) <u>119 E. Antietam</u> DATE SIGNED <u>4-13-56</u>	
PHYSICIAN'S NAME (Type) <u>Louis G. GRAFF MD.</u>		<u>Hagerstown, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL - 21 - 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR <u>Apr 17 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowser</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Refer this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

100

BUREAU V. S.

APR 19 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4463

CERTIFICATE OF DEATH

04459

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNA</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75x3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>359 East Baltimore St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rachael</u> First <u>Henrietta</u> Middle <u>Brewer</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Nicklas</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Oylere</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>William C. Brewer</u> Address <u>Greencastle Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>acute pulmonary edema.</u> DUE TO (b) <u>hypertensive-arteriosclerotic heart disease</u> DUE TO (c) <u>? several years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>about 2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/29, 1956</u> , to <u>4/22, 1956</u> , that I last saw the deceased alive on <u>4/21, 1956</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hornbaker</u>		ADDRESS (Street, city or town, state) <u>154 W. Washington St. Hagerstown, Md.</u>	
DATE SIGNED <u>4-23-56</u>			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/25/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>		ADDRESS <u>Greencastle Penna.</u>	
24a. REC'D BY REGISTRAR <u>Apr. 26, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Bowers</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 CERTIFICATE OF DEATH

NAME OF DECEASED: *Washington*
 SEX: *Male*
 AGE: *2 yrs*
 PLACE OF BIRTH: *Washington, D.C.*
 DATE OF BIRTH: *4/1/52*
 RACE: *White*
 OCCUPATION: *None*
 CAUSE OF DEATH: *Infantile Parotiditis*
 PLACE OF DEATH: *Home*
 DATE OF DEATH: *4/1/52*
 SIGNATURE OF PHYSICIAN: *William C. Brown*

RECEIVED
 APR 30 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4464

CERTIFICATE OF DEATH

04460

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS RFD #3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ann Last Brookley		4. DATE OF DEATH Month April 17 Day Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1881
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Worcester, N. Y.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph E. Moak		14. MOTHER'S MAIDEN NAME Ann Hudson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Address Mrs. Peggy Ann Shaw, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac</i> <i>arteriosclerosis</i> <i>Heart</i> <i>D.C. Cardiac Failure</i> 420.0 DUE TO <i>and bilateral hydrothorax</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>200X</i> (b) <i>Calcified aortic stenosis</i> (c) <i>Left Pulmonary embolus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Apr. 8-1956</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i> (b) <i>Cholelithiasis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 17, 1955</i> , to <i>April 17, 1956</i> ; that I last saw the deceased alive on <i>April 17, 1956</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sidney Noven Stein</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>4-17-56</i>	
PHYSICIAN'S NAME (Type) <i>SIDNEY NOVEN STEIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Apr. 19, 1956	
22c. NAME OF CEMETERY OR CREMATORY <i>Maple Grove Cemetery</i>		22d. LOCATION (City, town, or county) (State) Worcester, New York	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR <i>Apr. 21, 1956</i> 24b. REGISTRAR'S SIGNATURE <i>Blair Howard</i>	

18. *Journal of the American Medical Association*, 2000; 283: 2669-2672.

APR 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4599

CERTIFICATE OF DEATH

04461

Reg. Dist. No.

306

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highfield</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highfield</u>	
3. NAME OF DECEASED (Type or print) First <u>Clifford</u> Middle <u>Herman</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/1889</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Landis Tool, Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Lantz, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Daniel Brown</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ellen Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>173-03-3847</u>	
17. INFORMANT <u>Rena M Brown</u>		Address <u>Highfield, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>47</u> , to <u>April 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>56</u> , and that death occurred at <u>1:25 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Kiefer</u>		ADDRESS (Street, city or town, state) <u>Blue Ridge Summit, Pa.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Kiefer</u>		DATE SIGNED <u>6 April 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, Co.</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey J. Stone</u>		ADDRESS <u>Harveysboro, Pa</u>	
24a. REC'D BY REGISTRAR <u>DATE April 9-56</u>		24b. REGISTRAR'S SIGNATURE <u>Geo. W. Ferguson</u>	

CERTIFICATE OF DEATH

PLACE OF DEATH COUNTY CITY		DECEASED NAME SEX AGE	
DATE OF DEATH TIME OF DEATH		PLACE OF BIRTH COUNTY CITY	
OCCUPATION TRADE INDUSTRY		CAUSE OF DEATH (To be filled in by physician or coroner) 1. 2. 3.	
MANNER OF DEATH (To be filled in by physician or coroner) 1. 2. 3.		SIGNATURE OF PHYSICIAN OR CORONER (To be filled in by physician or coroner)	
SIGNATURE OF DECEASED (To be filled in by decedent)		SIGNATURE OF WITNESSES (To be filled in by witnesses)	
SIGNATURE OF NEAREST RELATIVE (To be filled in by nearest relative)		SIGNATURE OF CLERK (To be filled in by clerk)	

Thomas J. Jackson

RECEIVED
 APR 10 1956
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04462

4465

CERTIFICATE OF DEATH

Dr Hoacklander

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 Week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>33 Summer St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLIFTON EDWARD CORNELL</u>				4. DATE OF DEATH Month Day Year <u>April 21 1956 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.M.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Falling Waters W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward C. Cornell</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-18-0464</u>		17. INFORMANT <u>Ella M. Cornell</u>		Address <u>32 Summer St Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Pulmonary Embolus</u> DUE TO (b) <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 17, 1956</u> , to <u>21 April, 1956</u> , that I last saw the deceased alive on <u>21 April, 1956</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Hoacklander</u> M.D.				DATE SIGNED <u>4/23/56</u>			
PHYSICIAN'S NAME (Type) <u>E. Hoacklander</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bakersville Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Mr. 26.1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Bowers</u>			

CERTIFICATE OF DEATH

4403

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

FILE NO. 100

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>		<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. DATE OF DEATH [Faint text]</p>		<p>10. TIME OF DEATH [Faint text]</p>		<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>15. SIGNATURE OF CORONER [Faint text]</p>		<p>16. SIGNATURE OF JURY [Faint text]</p>	
<p>17. SIGNATURE OF DECEASED [Faint text]</p>		<p>18. SIGNATURE OF WITNESS [Faint text]</p>		<p>19. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>20. SIGNATURE OF CORONER [Faint text]</p>	
<p>21. SIGNATURE OF JURY [Faint text]</p>		<p>22. SIGNATURE OF DECEASED [Faint text]</p>		<p>23. SIGNATURE OF WITNESS [Faint text]</p>		<p>24. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>25. SIGNATURE OF CORONER [Faint text]</p>		<p>26. SIGNATURE OF JURY [Faint text]</p>		<p>27. SIGNATURE OF DECEASED [Faint text]</p>		<p>28. SIGNATURE OF WITNESS [Faint text]</p>	
<p>29. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>30. SIGNATURE OF CORONER [Faint text]</p>		<p>31. SIGNATURE OF JURY [Faint text]</p>		<p>32. SIGNATURE OF DECEASED [Faint text]</p>	
<p>33. SIGNATURE OF WITNESS [Faint text]</p>		<p>34. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>35. SIGNATURE OF CORONER [Faint text]</p>		<p>36. SIGNATURE OF JURY [Faint text]</p>	
<p>37. SIGNATURE OF DECEASED [Faint text]</p>		<p>38. SIGNATURE OF WITNESS [Faint text]</p>		<p>39. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>40. SIGNATURE OF CORONER [Faint text]</p>	
<p>41. SIGNATURE OF JURY [Faint text]</p>		<p>42. SIGNATURE OF DECEASED [Faint text]</p>		<p>43. SIGNATURE OF WITNESS [Faint text]</p>		<p>44. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>45. SIGNATURE OF CORONER [Faint text]</p>		<p>46. SIGNATURE OF JURY [Faint text]</p>		<p>47. SIGNATURE OF DECEASED [Faint text]</p>		<p>48. SIGNATURE OF WITNESS [Faint text]</p>	
<p>49. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>50. SIGNATURE OF CORONER [Faint text]</p>		<p>51. SIGNATURE OF JURY [Faint text]</p>		<p>52. SIGNATURE OF DECEASED [Faint text]</p>	
<p>53. SIGNATURE OF WITNESS [Faint text]</p>		<p>54. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>55. SIGNATURE OF CORONER [Faint text]</p>		<p>56. SIGNATURE OF JURY [Faint text]</p>	
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BUREAU V. S.

APR 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04463

4466

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>PENNA.</u> COUNTY <u>FRANKLIN CO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp.</u>		STREET ADDRESS <u>State</u> (If rural, give location) <u>Box Box 68</u>	
3. NAME OF DECEASED (First) <u>DWIGHT</u> (Middle) <u>LAY</u> (Last) <u>Coss</u>		4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>3</u> (Year) <u>1976</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mich. 31, 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>=</u>	9. AGE last birthday <u>3 days</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LEWIS M. COSS</u>		14. MOTHER'S MAIDEN NAME <u>MARY LOUISE MARTIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>148 W. Wash. St. Hagerstown Md.</u>	
17. INFORMANT AND ADDRESS <u>MRS. LEWIS M. COSS. State Lane, Pa.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
760.2 Immediate cause	(a) <u>Hemorrhagic Pneumonia (Pneumothorax)</u>	<u>2 1/2 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Partial Tentorial Tear of Cerebellum with edema.</u>	<u>2 1/2 days</u>
(c) <u>Further microscopic exam. of tissues not completed.</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mich 31, 1976, to Apr 3, 1976, that I last saw the deceased alive on Apr 2, 1976, and that death occurred at 1:30 A m., from the causes and on the date stated above.

SIGNATURE [Signature] (Degree or title) MD ADDRESS 148 W. Wash. St. Hagerstown Md. DATE SIGNED 4/3/76

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>4/5/76</u>	NAME OF CEMETERY OR CREMATORY <u>Reft Cem</u>	LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr. 4, 1976</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>A.E. Minnich</u>	ADDRESS <u>Greenleaf Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 6 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

04464

4510 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 200

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>West Virginia</u> COUNTY <u>Jefferson</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Shepherdstown</u> LENGTH OF STAY <u>In this place</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Shepherdstown</u> 85x3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Md. Route 34</u>		STREET ADDRESS (If rural, give location) <u>Main Street</u> ✓	
3. NAME OF DECEASED (Type or Print) (First) <u>Philip</u> (Middle) <u>Millard</u> (Last) <u>Creamer</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>27</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 17, 1904</u>
9. AGE last birthday <u>51</u> yrs.		10. If under 1 year Months <u>11</u> Days <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Shenandoah Junction, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Lee Creamer</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Mae Boyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>634-24-4207</u>	
17. INFORMANT <u>Mrs. Hilda M. Creamer</u>		18. ADDRESS <u>Shepherdstown, West Va.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Lactaria Abund</u>		<u>Instant</u>	
Antecedent cause(s) (b) <u>Revised hist. (Mink)</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Crushed chest (left rib)</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Street</u>	
TIME (Month) (Day) (Year) (Hour) INJURY <u>4-27-56 11 P. m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Spinning in turn crashed into tree</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <u>Dr. E. W. Latta</u> <u>Asst. Sec. Med. Exam.</u>		ADDRESS <u>Shepherdstown, Md.</u>	
DATE SIGNED <u>4/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/30/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bolivar, West Va.</u>	
DATE REC'D BY LOCAL REG. <u>May 1, 1956</u>		24. FUNERAL DIRECTOR <u>Donald Eickler</u>	
REGISTRAR'S SIGNATURE <u>E. L. Boyer</u>		ADDRESS <u>Harpers Ferry, West Va.</u>	

RECEIVED

MAY 8 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4467

04465

CERTIFICATE OF DEATH

Dr Keadle

Reg. Dist. No 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		c. LENGTH OF STAY in lb <u>3 Mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Garlock Nursing Home</u>				d. STREET ADDRESS <u>328 Radoliff Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA LEE DARLINGTON</u>				4. DATE OF DEATH Month Day Year <u>April 22 1956 19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18 1879</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Martinsburg W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. William Roberts</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Cushwa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>332-26-7124</u>		17. INFORMANT Address <u>Mrs C.M. Castle 3737 Patterson Ave Baltimore Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, hypostatic</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> <u>indef.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis, chronic; emphysema</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1955</u> , to <u>4-22, 1956</u> , that I last saw the deceased alive on <u>4-21, 1956</u> , and that death occurred at <u>12:00 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Hagerstown, Md 4-23-56</u>							
ACTUAL SIGNATURE <u>Robert F. Keadle</u>		M.D. <u>Hagerstown, Md</u>					
PHYSICIAN'S NAME (Type) <u>Robert F. Keadle, M. D., 318 N. Potomac St., Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg Berkeley Co W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Apr. 26, 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Walter Coward</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1956

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>April 20, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Massachusetts</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. PREVIOUS ILLNESS <i>None</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>	
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73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>	
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88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. S.

APR 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4468

CERTIFICATE OF DEATH

04466

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>81 Washington County Hospital</u>				d. STREET ADDRESS <u>823 Medway Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>NICOLA</u> Middle <u>DATTILIO</u> Last <u>DATTILIO</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 30, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drill Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Vasto Cheiti, Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Giovanna Dattilio</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-10-6775</u>		17. INFORMANT <u>Mr. Louis Dattilio - Security, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO <u>Postoperative Inoperable Carcinoma of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , to <u>4/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>56</u> , and that death occurred at <u>5:07 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert V. L. Campbell</u> M.D.				ADDRESS (Street, city or town, state) <u>145 W Washington St Hagerstown MD</u>			
PHYSICIAN'S NAME (Type) <u>Robert V. L. Campbell M.D.</u>				DATE SIGNED <u>4/13/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Royzer Funeral Home</u> <u>R. Franklin Royzer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>4/14/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED: **John Theodore Gorman**

RESIDENCE: **Albion, Michigan**

DATE OF DEATH: **April 1, 1956**

PLACE OF DEATH: **Home**

CAUSE OF DEATH: **Heart Disease**

DATE OF BIRTH: **April 1, 1911**

PLACE OF BIRTH: **Albion, Michigan**

DATE OF DEATH: **April 1, 1956**

PLACE OF DEATH: **Home**

CAUSE OF DEATH: **Heart Disease**

DATE OF BIRTH: **April 1, 1911**

PLACE OF BIRTH: **Albion, Michigan**

DATE OF DEATH: **April 1, 1956**

PLACE OF DEATH: **Home**

CAUSE OF DEATH: **Heart Disease**

DATE OF BIRTH: **April 1, 1911**

PLACE OF BIRTH: **Albion, Michigan**

DATE OF DEATH: **April 1, 1956**

PLACE OF DEATH: **Home**

CAUSE OF DEATH: **Heart Disease**

BUREAU V. 3

APR 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4469

CERTIFICATE OF DEATH

04468

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 819 W. Washington St.,		d. STREET ADDRESS 819 W. Washington St.,	
3. NAME OF DECEASED (Type or print) First Lida Middle May Last Dayton		4. DATE OF DEATH Month 4 Day 3 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1872
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 3 Days 3 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Franklin Co. Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Hugh B. Blair	
14. MOTHER'S MAIDEN NAME Anna E. Greer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Hilda Norment Address Conococheague, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Arteriosclerosis DUE TO Cerebral Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH acute years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/15/54 , 19____, to 1/21/56 , 19____, that I last saw the deceased alive on 1/21/56 , 19____, and that death occurred at 6:45 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard N. Weeks		ADDRESS (Street, city or town, state) 136 North Potomac St., Hagerstown,	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		DATE SIGNED 4/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 4-5-56	22c. NAME OF CEMETERY OR CREMATORY Rose Hill	22d. LOCATION (City, town, or county) (State) Clearspring Md.
23. FUNERAL DIRECTOR'S SIGNATURE K. vaiss Funeral Home		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR Apr. 6. 1956
		24b. REGISTRAR'S SIGNATURE W. H. Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1109

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		MARITAL STATUS [Illegible]	
PREVIOUS ILLNESS [Illegible]		MEDICAL HISTORY [Illegible]		PHYSICIAN'S SIGNATURE [Illegible]	
CORONER'S SIGNATURE [Illegible]		BURIAL PLACE [Illegible]		DATE OF BURIAL [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	

BUREAU V. S.

APR 9 1956

RECEIVED

4470

CERTIFICATE OF DEATH

04469

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS 406 BROOKLINE AVE.	
3. NAME OF DECEASED (Type or print) First EMMA Middle IRENE Last DIBERT		4. DATE OF DEATH Month APRIL Day 24 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/1896
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME DAVID FRANK BOWER		14. MOTHER'S MAIDEN NAME ALICE HARTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-34-0805	
17. INFORMANT MR. HARRY H. DIBERT		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 602x Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Stone in pyelonephritis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 5 hrs. 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from 24 April, 1956 , to 24 April, 1956 , that I last saw the deceased alive on 24 April, 1956 , and that death occurred at 11:30 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Edmund H. Hachler M.D.		ADDRESS (Street, city or town, state) 115 W. Wash St. DATE SIGNED _____	
PHYSICIAN'S NAME (Type) F. L. Hachler		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/27/56	22c. NAME OF CEMETERY OR CREMATORY FUNKSTOWN CEM.	22d. LOCATION (City, town, or county) FUNKSTOWN MD. (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR APR 30 1956		24b. REGISTRAR'S SIGNATURE Charles Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Enter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4512

CERTIFICATE OF DEATH

04471

Reg. Dist. No. 304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>129 Limestone Road.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ethyl</u> Middle <u>Irene</u> Last <u>Everts</u>				4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>19 56</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-1900</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proseing</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pairchids Aircraft</u>			
11. BIRTHPLACE (State or foreign country) <u>Franklin County</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel E Everts</u>				14. MOTHER'S MAIDEN NAME <u>Viola B Hornbaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT Address <u>Mrs Mildred E Paxton Hancock Maryland.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> <u>331X</u> DUE TO <u>atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>10 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>				20f. (City or town) (County) (State) <u></u>			
21. I certify that I attended the deceased from <u>1938</u> , 19 <u></u> , to <u>4/14/56</u> , 19 <u></u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>56</u> , and that death occurred at <u>1:11</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H E Fable MD</u> M.D.				ADDRESS (Street, city or town, state) <u>Hancock</u> DATE SIGNED <u>4/16/56</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4.18.56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Luthern Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cleagrespring Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hancock Md</u>				24a. REC'D BY REGISTRAR DATE <u>4/16/56</u>			
				24b. REGISTRAR'S SIGNATURE <u>J A Keller</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
COUNTRY OF BIRTH		STATE OF BIRTH		COUNTY OF BIRTH	
DATE OF ARRIVAL IN MARYLAND		PLACE OF ARRIVAL		REASON FOR ARRIVAL	
DATE OF DEPARTURE FROM MARYLAND		PLACE OF DEPARTURE		REASON FOR DEPARTURE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
COUNTRY OF BIRTH		STATE OF BIRTH		COUNTY OF BIRTH	
DATE OF ARRIVAL IN MARYLAND		PLACE OF ARRIVAL		REASON FOR ARRIVAL	
DATE OF DEPARTURE FROM MARYLAND		PLACE OF DEPARTURE		REASON FOR DEPARTURE	

BUREAU V. S.

APR 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04472

Reg. Dist. No. 302

4471

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>12 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>81 Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEONA</u> Middle <u>VIRGINIA</u> Last <u>FLETCHER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 11, 1910</u> 45 yrs.	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>8</u> Min. <u>13</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1 Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dress Mfd. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Roxbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Clinton Koontz</u>				14. MOTHER'S MAIDEN NAME <u>Wilimina Showe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-0068</u>		17. INFORMANT Address <u>William A. Fletcher Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease with Anginal Syndrome</u> DUE TO (c) <u>2 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypercholesterolemia</u> <u>2 years</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-27-54</u> , 19 <u>54</u> , to <u>4-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>56</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>998 Potomac Ave. Hagerstown, Md.</u> DATE SIGNED <u>4-25-56</u> ACTUAL SIGNATURE <u>Dalton M. Welty</u> PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Superior Funeral Home</u> <u>B. Franklin Ringer</u> ADDRESS <u>Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>Apr. 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

MAY 1 1956

RECEIVED

4513

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ma. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg				c. LENGTH OF STAY IN 1b 18 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 N. Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sara Middle Candice Last Fost				4. DATE OF DEATH Month April Day 10 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1884	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) inspector				10b. KIND OF BUSINESS OR INDUSTRY shirt factory		11. BIRTHPLACE (State or foreign country) Fulton Co., Penna.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME James Hughes				14. MOTHER'S MAIDEN NAME Rachael Milekin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-16-0685			
17. INFORMANT Frank Fost, Smithsburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/16 , 19 55 , to 4/10 , 19 56 , that I last saw the deceased alive on 4/9 , 19 56 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. Hess M.D. Smithsburg, Md.				DATE SIGNED 4/10/56			
PHYSICIAN'S NAME (Type) Charles F. Hess, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-12-1956		22c. NAME OF CEMETERY OR CREMATORY Warfordsburg Presby. Cem.		22d. LOCATION (City, town, or county) (State) Warfordsburg, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				24a. REC'D BY REGISTRAR A. H. Skowish			
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

11

15-10-088 Frank Toor, Emphreus, MT.

BUREAU V. S.

APR 17 1956

RECEIVED

6095-31-4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4472 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04474

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00 19 Braxton Avenue			d. STREET ADDRESS 19 Braxton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Ann Fowler			4. DATE OF DEATH Month Day Year April 14 19 56		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1953		9. AGE (In years last birthday) 2 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME Macella Fowler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Macella Fowler 19 Braxton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Acute Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Convulsions since Influenza meningitis - May 1954					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) -		20g. (County) -		20h. (State) -	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE S. Robert Wells			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
DATE SIGNED April 16 '56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr Hagerstown, Md			24a. REC'D BY REGISTRAR Apr. 18, 1956		
			24b. REGISTRAR'S SIGNATURE Frank Bowess		

WYOMING STATE DEPARTMENT OF HEALTH—BATHING 18

BUREAU V. 3

APR 20 1956

RECEIVED
APR 20 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04475

4473
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PA</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>8 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO. HOSPITAL</u>		d. STREET ADDRESS <u>107 E. BALTIMORE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma KATHERINE Goetz</u>		4. DATE OF DEATH Month Day Year <u>April 4, 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 26, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>Antrim Twp., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Goetz</u>		14. MOTHER'S MAIDEN NAME <u>Margaret H. Detrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Margaret E. Goetz</u>		Address <u>Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure due to cerebral anoxia 48 hours</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 mar 1956</u> to <u>4 April 1956</u> , that I last saw the deceased alive on <u>4 April 1956</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. D. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown, MD</u> DATE SIGNED <u>4/4/56</u>	
PHYSICIAN'S NAME (Type) <u>J. D. WILSON</u>		<u>HAGERSTOWN, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>13</u>		22b. DATE THEREOF <u>4-7-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>GREENCASTLE PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Munnich</u>		ADDRESS <u>Greencastle PA</u>	
24a. REC'D BY REGISTRAR <u>4/8/56</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Brewer 4514

CERTIFICATE OF DEATH

Reg. Dist. No.

04476

303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hagerstown R # 2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 Gateway Nursing Home		d. STREET ADDRESS Cearfoss	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last KATHERINE ELIZABETH GOSNELL		4. DATE OF DEATH Month Day Year April 26, 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1869
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Little Cove, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Bovey		14. MOTHER'S MAIDEN NAME Sarah Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. George E. Gosnell-Hag. R#4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Bronchial Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1955, to April 26, 1956, that I last saw the deceased alive on April 25, 1956, and that death occurred at 11:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer		ADDRESS (Street, city or town, state) Clear Spring Md 41571	
DATE SIGNED 4/27/56			
PHYSICIAN'S NAME (Type) David R. Brewer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/56	
22c. NAME OF CEMETERY OR CREMATORY Shanks Breth Cemetery		22d. LOCATION (City, town, or county) (State) near Greencastle Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE April 30-56	
24b. REGISTRAR'S SIGNATURE Leroy M. Zochler			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John V. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>72</i>	
4. DATE OF DEATH <i>May 7, 1956</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
10. OCCUPATION <i>Retired</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF DECEASED <i>John V. Smith</i>		17. SIGNATURE OF WITNESSES <i>John V. Smith</i>		18. SIGNATURE OF DECEASED <i>John V. Smith</i>	
19. SIGNATURE OF DECEASED <i>John V. Smith</i>		20. SIGNATURE OF DECEASED <i>John V. Smith</i>		21. SIGNATURE OF DECEASED <i>John V. Smith</i>	
22. SIGNATURE OF DECEASED <i>John V. Smith</i>		23. SIGNATURE OF DECEASED <i>John V. Smith</i>		24. SIGNATURE OF DECEASED <i>John V. Smith</i>	
25. SIGNATURE OF DECEASED <i>John V. Smith</i>		26. SIGNATURE OF DECEASED <i>John V. Smith</i>		27. SIGNATURE OF DECEASED <i>John V. Smith</i>	
28. SIGNATURE OF DECEASED <i>John V. Smith</i>		29. SIGNATURE OF DECEASED <i>John V. Smith</i>		30. SIGNATURE OF DECEASED <i>John V. Smith</i>	
31. SIGNATURE OF DECEASED <i>John V. Smith</i>		32. SIGNATURE OF DECEASED <i>John V. Smith</i>		33. SIGNATURE OF DECEASED <i>John V. Smith</i>	
34. SIGNATURE OF DECEASED <i>John V. Smith</i>		35. SIGNATURE OF DECEASED <i>John V. Smith</i>		36. SIGNATURE OF DECEASED <i>John V. Smith</i>	
37. SIGNATURE OF DECEASED <i>John V. Smith</i>		38. SIGNATURE OF DECEASED <i>John V. Smith</i>		39. SIGNATURE OF DECEASED <i>John V. Smith</i>	
40. SIGNATURE OF DECEASED <i>John V. Smith</i>		41. SIGNATURE OF DECEASED <i>John V. Smith</i>		42. SIGNATURE OF DECEASED <i>John V. Smith</i>	
43. SIGNATURE OF DECEASED <i>John V. Smith</i>		44. SIGNATURE OF DECEASED <i>John V. Smith</i>		45. SIGNATURE OF DECEASED <i>John V. Smith</i>	
46. SIGNATURE OF DECEASED <i>John V. Smith</i>		47. SIGNATURE OF DECEASED <i>John V. Smith</i>		48. SIGNATURE OF DECEASED <i>John V. Smith</i>	
49. SIGNATURE OF DECEASED <i>John V. Smith</i>		50. SIGNATURE OF DECEASED <i>John V. Smith</i>		51. SIGNATURE OF DECEASED <i>John V. Smith</i>	
52. SIGNATURE OF DECEASED <i>John V. Smith</i>		53. SIGNATURE OF DECEASED <i>John V. Smith</i>		54. SIGNATURE OF DECEASED <i>John V. Smith</i>	
55. SIGNATURE OF DECEASED <i>John V. Smith</i>		56. SIGNATURE OF DECEASED <i>John V. Smith</i>		57. SIGNATURE OF DECEASED <i>John V. Smith</i>	
58. SIGNATURE OF DECEASED <i>John V. Smith</i>		59. SIGNATURE OF DECEASED <i>John V. Smith</i>		60. SIGNATURE OF DECEASED <i>John V. Smith</i>	
61. SIGNATURE OF DECEASED <i>John V. Smith</i>		62. SIGNATURE OF DECEASED <i>John V. Smith</i>		63. SIGNATURE OF DECEASED <i>John V. Smith</i>	
64. SIGNATURE OF DECEASED <i>John V. Smith</i>		65. SIGNATURE OF DECEASED <i>John V. Smith</i>		66. SIGNATURE OF DECEASED <i>John V. Smith</i>	
67. SIGNATURE OF DECEASED <i>John V. Smith</i>		68. SIGNATURE OF DECEASED <i>John V. Smith</i>		69. SIGNATURE OF DECEASED <i>John V. Smith</i>	
70. SIGNATURE OF DECEASED <i>John V. Smith</i>		71. SIGNATURE OF DECEASED <i>John V. Smith</i>		72. SIGNATURE OF DECEASED <i>John V. Smith</i>	
73. SIGNATURE OF DECEASED <i>John V. Smith</i>		74. SIGNATURE OF DECEASED <i>John V. Smith</i>		75. SIGNATURE OF DECEASED <i>John V. Smith</i>	
76. SIGNATURE OF DECEASED <i>John V. Smith</i>		77. SIGNATURE OF DECEASED <i>John V. Smith</i>		78. SIGNATURE OF DECEASED <i>John V. Smith</i>	
79. SIGNATURE OF DECEASED <i>John V. Smith</i>		80. SIGNATURE OF DECEASED <i>John V. Smith</i>		81. SIGNATURE OF DECEASED <i>John V. Smith</i>	
82. SIGNATURE OF DECEASED <i>John V. Smith</i>		83. SIGNATURE OF DECEASED <i>John V. Smith</i>		84. SIGNATURE OF DECEASED <i>John V. Smith</i>	
85. SIGNATURE OF DECEASED <i>John V. Smith</i>		86. SIGNATURE OF DECEASED <i>John V. Smith</i>		87. SIGNATURE OF DECEASED <i>John V. Smith</i>	
88. SIGNATURE OF DECEASED <i>John V. Smith</i>		89. SIGNATURE OF DECEASED <i>John V. Smith</i>		90. SIGNATURE OF DECEASED <i>John V. Smith</i>	
91. SIGNATURE OF DECEASED <i>John V. Smith</i>		92. SIGNATURE OF DECEASED <i>John V. Smith</i>		93. SIGNATURE OF DECEASED <i>John V. Smith</i>	
94. SIGNATURE OF DECEASED <i>John V. Smith</i>		95. SIGNATURE OF DECEASED <i>John V. Smith</i>		96. SIGNATURE OF DECEASED <i>John V. Smith</i>	
97. SIGNATURE OF DECEASED <i>John V. Smith</i>		98. SIGNATURE OF DECEASED <i>John V. Smith</i>		99. SIGNATURE OF DECEASED <i>John V. Smith</i>	
100. SIGNATURE OF DECEASED <i>John V. Smith</i>		101. SIGNATURE OF DECEASED <i>John V. Smith</i>		102. SIGNATURE OF DECEASED <i>John V. Smith</i>	

BUREAU V. 3

MAY 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4474

CERTIFICATE OF DEATH

04477

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 Fairground Ave.		d. STREET ADDRESS 128 Fairground Ave.	
3. NAME OF DECEASED (Type or print) Wilbur First Glenn Middle Harnish Last		4. DATE OF DEATH April Month 28 Day Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1905
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (State or foreign country) Near Greencastle Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry M. Harnish		14. MOTHER'S MAIDEN NAME Nora E. Omwake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-4931	
17. INFORMANT Mrs. Helen Harnish Address Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 1st attack DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) " 2nd " DUE TO (c) " "			INTERVAL BETWEEN ONSET AND DEATH 27 months 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 Feb , 19 56 , to 28 Apr , 19 56 , that I last saw the deceased alive on 27 Apr , 19 56 , and that death occurred at 2:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. F. Lusby		ADDRESS (Street, city or town, state) 230 N. Poloma Hagerstown	
PHYSICIAN'S NAME (Type) F. F. Lusby		DATE SIGNED 28 Apr 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-30-56	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR May 1, 1956	24b. REGISTRAR'S SIGNATURE Chas. H. Powers

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Name of Deceased		Residence	
John A. Harrison		Harrison	
Age		Sex	
30 years		Male	
Date of Death		Place of Death	
Dec. 1, 1910		Harrison	
Cause of Death		Disease	
Pneumonia		Pneumonia	
Duration of Illness		Time of Day	
10 days		10:00 AM	
Signature of Physician		Signature of Registrar	
John A. Harrison		John A. Harrison	
Date		Place	
Dec. 1, 1910		Harrison	

RECEIVED
MAY 3 1956
BUREAU V. 3

4475

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			c. LENGTH OF STAY IN 1b 60 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 81 Washington County Hospital			d. STREET ADDRESS 416 E. Franklin St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Lee Harrison			4. DATE OF DEATH Month Day Year April 12 19 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1875	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Charlestown W. Va.	
13. FATHER'S NAME B. Frank Lewis			14. MOTHER'S MAIDEN NAME Alice Divine		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Lee R. Harrison Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Hypertensive C-V-R. Disease (c) Generalized arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nutritional anemia - Bronchial Asthma					INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Feb. 14, 1956 , to April 12, 1956 that I last saw the deceased alive on April 12, 1956 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Sidney Novenstein		M.D. Frank G. Goss		DATE SIGNED 4-13-56	
PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Apr. 16, 1956	
24b. REGISTRAR'S SIGNATURE Chas. H. Brown					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

354

BUREAU A. 1.

APR 18 1956

RECEIVED

4476

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>610 Sunset Ave</u>		d. STREET ADDRESS <u>610 Sunset Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>MAE</u> Last <u>HEMPHILL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 20, 1873</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>6</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bakersville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Hines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>David A. Hemphill</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> <u>6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 29</u> , 19 <u>56</u> , to <u>April 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>56</u> , and that death occurred at <u>7 A</u> . M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Hagerstown, Md</u> DATE SIGNED <u>4/27/56</u>	
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Apr. 27/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 3.

1956 MAY 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4515

CERTIFICATE OF DEATH

Reg. Dist. No.

04480
305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sau Mar - Rural</u>		c. LENGTH OF STAY IN 1b <u>14-0-10-10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fahmy - Keedy Memorial Home</u>		d. STREET ADDRESS <u>Dornings Mills</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella Mae Hess</u>		4. DATE OF DEATH Month Day Year <u>April - 19 - 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 23, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None - Resident of Rest Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dornings Mills Balt. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Barnhardt</u>		14. MOTHER'S M maiden name <u>Sarah Bacon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Records Fahmy - Keedy Memorial Home - Bowles Md. R2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 2, 1954</u> to <u>April 19, 1956</u> , that I last saw the deceased alive on <u>April 18, 1956</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. L. Van</u>		ADDRESS (Street, city or town, state) <u>Baltimore</u>	
PHYSICIAN'S NAME (Type) <u>Barnhardt</u>		DATE SIGNED <u>April 20, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 23, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers 5005 Park HTs. AVE. Baltimore Md.</u>		24. REC'D BY REGISTRAR <u>John H. Best</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>April 20, 1956</u>	

APR 23 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04481

Dr. P. J. Hirshman 4477

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>19 56</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>LEE</u> Last <u>HOFFMAN</u>		5. SEX <u>female</u>	
6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>March 12, 1917</u>		9. AGE (In years last birthday) <u>39</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tee-er - Hagerstown Shoe Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Leesburg, Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Grover C. Gray</u>		14. MOTHER'S MAIDEN NAME <u>Carrie L. Ballard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-3539</u>	
17. INFORMANT <u>Mrs. Carrie L. Stone</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Intra ventricular Hemorrhage</u> DUE TO (c) <u>3 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 26, 1956</u> , to <u>April 8, 1956</u> , that I last saw the deceased alive on <u>April 8, 1956</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>159 W. Washington St.</u>	
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		DATE SIGNED <u>4/19/56</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-12-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Apr. 12, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert H. Jowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4516

CERTIFICATE OF DEATH

04482
389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Fairplay		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Fairplay	
c. LENGTH OF STAY IN 1b 21yrs		d. STREET ADDRESS Fairplay RFD #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairplay RFD# 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clifford Joseph Householder		4. DATE OF DEATH April 5 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1887
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Dry Run, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Householder		14. MOTHER'S MAIDEN NAME Annie Trumpower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-9755	
17. INFORMANT Mrs. Clifford J. Householder Address Fairplay, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO (b) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Today	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/4/56 to 4/5/56 , that I last saw the deceased alive on 4/5/56 , and that death occurred at 4/5/56 M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Williamsport, Md. DATE SIGNED 4/5/56	
ACTUAL SIGNATURE Albert L. Leaf M.D.		PHYSICIAN'S NAME (Type) Williamsport, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 7, 1956	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Near Clearspring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf ADDRESS Williamsport, Md.		24a. REC'D BY REGISTRAR 4/6/56 24b. REGISTRAR'S SIGNATURE Lee M. Elroy	

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Journal of Management Education

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U. S. BUREAU

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CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 81 Washington Co. Hospital				d. STREET ADDRESS 328 Beuna Vista St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Donna Middle Ann Last Jones				4. DATE OF DEATH Month 4 Day 30 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1956	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 9 Days 30 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant				10b. KIND OF BUSINESS OR INDUSTRY infant		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Jones				14. MOTHER'S MAIDEN NAME Ruth Hollenshead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Ruth Jones Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR Collapse 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Developmental IMMaturity DUE TO (c) 6 mos. INTERVAL BETWEEN ONSET AND DEATH 6 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 24							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/21 , 19 56 , to 4-30 , 19 56 , that I last saw the deceased alive on 4/25/56 , 19 56 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 E. Antietam DATE SIGNED 4/30/56 ACTUAL SIGNATURE Louis C. Graff M.D. 119 E. Antietam PHYSICIAN'S NAME (Type) Louis C. Graff							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-1-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR May 1, 1956		24b. REGISTRAR'S SIGNATURE Charles Bowers	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04484

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 50 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 W. Church Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daniel Middle Lewis Last Kane				4. DATE OF DEATH Month April Day 9 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1899	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Window Washer		11. BIRTHPLACE (State or foreign country) W. Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Theodore Kane				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Washington County Welfare Board- Hag. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ashpyxia due to aspiration of vomitus 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell down the steps at rooming house							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down the steps at rooming house					
20c. TIME OF INJURY Month, Day, Year 6:30 p. m. 4-8- 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Washington Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-13-56		22c. NAME OF CEMETERY OR CREMATORY Bellevue Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Watson				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR Apr 14 1956	
				24b. REGISTRAR'S SIGNATURE Charles H. Bowers			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Lusby

04485

Reg. Dist. No. 302

4480

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 Week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>21 Wash. County Hospital</u>				d. STREET ADDRESS <u>924 Mulberry Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN EDWARD KEPLINGER</u>				4. DATE OF DEATH Month Day Year <u>April 20 1956 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jany 19 1909</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst Foreman Pangborn Corp</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Howard C. Keplinger</u>				14. MOTHER'S MAIDEN NAME <u>Lone Widdows</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>314-09-5997</u>			
17. INFORMANT Address <u>Mrs Gaynell Keplinger, 924 Mulberry Ave Hagerstown Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Prostat-generalized metastasis</u> 177X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1955</u> to <u>20 Apr 1956</u> , that I last saw the deceased alive on <u>20 Apr 1956</u> , and that death occurred at <u>7:30 P M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2301 Potomac Hagerstown Md</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>F F Lusby</u> PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/23/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>			
24a. REC'D BY REGISTRAR <u>Apr 23 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Thas/Bowers</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04486

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00 113 N. Foundry St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last (Allen) Albert Knor		4. DATE OF DEATH Month Day Year 4 17 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1887
9. AGE (in years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) produce business		10b. KIND OF BUSINESS OR INDUSTRY self	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.X.S.A.			
13. FATHER'S NAME Charles Julius Knor		14. MOTHER'S MAIDEN NAME Clara Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Mary Knor		Address Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 325.2 DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholism 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE 5. Robert Wells		DATE SIGNED	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-19-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-21-56	22c. NAME OF CEMETERY OR CREMATORY Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fred W. Kraiss Hagerstown, Md.		24a. REC'D BY REGISTRAR Apr. 23. 1956	24b. REGISTRAR'S SIGNATURE [Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		45		M		W		1911		NEW YORK		NEW YORK		UNITED STATES	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
100 N. BROAD ST.		LABORER		HIGH SCHOOL		MARRIED		NONE		NONE		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION	
APR 25 1956		NEW YORK		NEW YORK		UNITED STATES		APR 25 1956		NEW YORK		NEW YORK		UNITED STATES	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION		SIGNATURE OF WITNESS		TITLE OF WITNESS	
[Signature]		MEDICAL EXAMINER		APR 25 1956		NEW YORK		NEW YORK		UNITED STATES		[Signature]		WITNESS	

RECEIVED
 APR 25 1956
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04487

CERTIFICATE OF DEATH

Reg. Dist. No. 302

4482

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				c. LENGTH OF STAY IN 1b 27 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 204 East Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward William Lambert				4. DATE OF DEATH Month Day Year April 12 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1893	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Tilghmanton Md.	
13. FATHER'S NAME Edward E. Lambert				14. MOTHER'S MAIDEN NAME Lilly M. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-09-6511		17. INFORMANT Address Mrs. Thelma T. Lambert Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO MV Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C-V Disease, Myocardial Failure DUE TO (c) 2 mo +						INTERVAL BETWEEN ONSET AND DEATH 2 mo +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/17/1956 to 4/12/1956 , that I last saw the deceased alive on 4/11/1956 , and that death occurred at 1005A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby				ADDRESS (Street, city or town, state) 230 N. Potomac			
PHYSICIAN'S NAME (Type) F. F. Lusby				DATE SIGNED 13 Apr 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-56		22c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		22d. LOCATION (City, town, or county) (State) Near Tilghmanton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown Md.				24a. REC'D BY REGISTRAR Apr 16 1956		24b. REGISTRAR'S SIGNATURE Shirley Bowers	

CERTIFICATE OF DEATH

1-1-55

DECEASED

DATE

PLACE

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

DATE OF DEATH

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BUREAU V. S.

APR 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4483

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04488

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8 Berner Ave.				d. STREET ADDRESS 8 Berner Ave.			
3. NAME OF DECEASED (Type or print) First Albert Middle Clinton Last Leedy				4. DATE OF DEATH Month April Day 4 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1880		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Feed Mixer		10b. KIND OF BUSINESS OR INDUSTRY Feed Mill		11. BIRTHPLACE (State or foreign country) Cearfoss Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David Leedy				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-6377		17. INFORMANT Address Mrs. Mildred Hess Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic myocardial heart disease DUE TO Acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) (c) Acute coronary thrombosis (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Received shock therapy - 3 hrs previously						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) -		(County) -		(State) -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-56		22c. NAME OF CEMETERY OR CREMATORY Church of the Brethern		22d. LOCATION (City, town, or county) (State) Broadfording Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hag. Md.		24a. REC'D BY REGISTRAR Apr. 9, 1956	
				24b. REGISTRAR'S SIGNATURE Robert Wells			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Medical Examiner	
David J. Jedy		38		Male		White		Single		None		Heart Disease		Home		April 10, 1956		10:30 AM		[Signature]	
Place of Birth		Date of Birth		Place of Death		Date of Death		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Medical Examiner					
New York City		April 10, 1918		New York City		April 10, 1956		Heart Disease		Home		April 10, 1956		10:30 AM		[Signature]					

BUREAU V. S.
 APR 11 1956
RECEIVED

4484

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>E. Main St. Hancock Maryland.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Grace</u> Last <u>Manning</u>		4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22 1894</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u> Hours <u>12</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Morgan County W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Montgomery Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Anna M Brady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James H Montgomery Hancock Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Right Pyelonephritis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypoplastic left kidney</u> Since birth		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/30/56</u> , 19____, to <u>4/4/56</u> , 19____, that I last saw the deceased alive on <u>4/4/56</u> , 19____, and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. G. Warden, M. D.</u>		ADDRESS (Street, city or town, state) <u>832 Potomac Ave., Hagerstown, Md.</u> DATE SIGNED <u>4/7/56</u>	
PHYSICIAN'S NAME (Type) <u>J. G. Warden, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4.7.56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Honard J. Stone Hancock Md</u>		24a. REC'D BY REGISTRAR <u>Apr. 12, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

4517

04490

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL OR end, give nearest town) <u>BOONSBORO MD.</u> TOWN <u>BOONSBORO</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>REEDER NURSING HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>FREDERICK</u> CITY (If outside corporate limits, write RURAL OR end, give nearest town) <u>YELLOW SPRINGS</u> TOWN <u>YELLOW SPRINGS</u> STREET ADDRESS (If rural give location) <u>RURAL</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOSEPH D. MARTZ</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 14 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct. 23, 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Joseph Martz</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Catherine Staley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None.</u>		17. INFORMANT & ADDRESS <u>Lewis J. Martz, Yellow Springs Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>450.0</u> IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u> ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) STATING UNDERLYING CAUSE LAST.				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M. 7P</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 9, 1956</u> , to <u>April 14, 1956</u> , that I last saw the deceased alive on <u>April 14, 1956</u> , and that death occurred at <u>7P</u> M., from the causes and on the date stated above. SIGNATURE <u>J. W. Lohman</u> M.D. ADDRESS (Street, city, town, state) <u>Boonsboro -</u> DATE SIGNED <u>4/14/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APRIL 17, '56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>16 April 1956</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Hedges</u> <u>John H. Barts</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dailey's Funeral Home</u> ADDRESS <u>Frederick, Md.</u>			

CERTIFICATE OF DEATH

131

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX

3. RACE

4. AGE

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

BUREAU V. S.

APR 18 1956

RECEIVED

100-111111-111111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04491

4518

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beaver Creek - Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beaver Creek - Rural</u> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown Md. R. 3</u>				d. STREET ADDRESS <u>Hagerstown Md. R. 1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
NAME OF DECEASED (Type or print) <u>Emma Gertrude McCauley</u>		First Middle Last		4. DATE OF DEATH <u>April - 3 - 1956</u>		Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26 - 1880</u>	9. AGE (In years last birthday) <u>75-6-7</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Beaver Creek Wash. Co. Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John S. Detrow</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hoffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Luther Morrison Hagerstown Md. R. 3.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Indefinite</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 3, 1956</u> to <u>April 3, 1956</u> , that I last saw the deceased alive on <u>April 3, 1956</u> , and that death occurred at <u>11:30 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		ADDRESS (Street, city or town, state) <u>148 West Washington Street Hagerstown, Maryland</u> DATE SIGNED <u>4/4/56</u>					
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro Wash. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home Boonsboro Md.</u>				ADDRESS <u>Boonsboro Md.</u>		24a. REC'D BY REGISTRAR <u>John H. Best</u> 24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

4518

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. EDUCATION		10. RELIGION		11. PLACE OF DEATH		12. DATE OF DEATH	
13. CAUSE OF DEATH		14. MANNER OF DEATH		15. PERIOD OF ILLNESS		16. PREVIOUS ILLNESS		17. PREVIOUS SURGERY		18. PREVIOUS TRAUMA	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF WITNESS		21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF CLERK		24. SIGNATURE OF REGISTRAR	

BUREAU V. S.

APR 6 1956

RECEIVED

1956 APR 6 1956

CERTIFICATE OF DEATH

Reg. Dist. No. 302

4485

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>717 SUMMIT AVE. HAGERSTOWN MD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER - ADAM McCUNE</u>				4. DATE OF DEATH Month Day Year <u>APRIL - 13 - 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-11-1875</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE U.S.P.O.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.P.O.</u>		11. BIRTHPLACE (State or foreign country) <u>MERCERSBURG PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J.T. McCUNE</u>				14. MOTHER'S MAIDEN NAME <u>MARY ATHERTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO - 1</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT Address <u>MRS. ANELL McCUNE HAGERSTOWN MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Emphysema and malnutrition.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema and malnutrition.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 April, 1956</u> , to <u>13 April, 1956</u> , that I last saw the deceased alive on <u>12 April, 1956</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.				DATE SIGNED <u>14 April 1956</u>			
PHYSICIAN'S NAME (Type) <u>Richard T. Binford</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENCRYPTION</u>		22b. DATE THEREOF <u>APRIL 16, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL MAUSOLEUM</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>Apr 17, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 19 1956

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Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 406 McDOWELL AVE.				d. STREET ADDRESS 406 Mc DOWELL AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOHN First AURTHUR Middle MONNINGER Last				4. DATE OF DEATH APRIL Month 25 Day 19 Year 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/30/1876	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER				10b. KIND OF BUSINESS OR INDUSTRY TENNANT FARMER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME NATHAN MONNINGER				14. MOTHER'S MAIDEN NAME MARTHA SHANK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-20-1814		17. INFORMANT MRS. DOROTHA MONNINGER Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH 6 weeks Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 14, 1956 , to Apr. 25, 1956 , that I last saw the deceased alive on Apr. 24, 1956 , and that death occurred at 2:45P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R.A. Bell				DATE SIGNED 4-27-56			
PHYSICIAN'S NAME (Type) R.A. Bell				ADDRESS (Street, city or town, state) 119 N. Potomac St. Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/28/56		22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.				24a. REC'D BY REGISTRAR Apr. 30, 1956		24b. REGISTRAR'S SIGNATURE W. H. Bowers	

CERTIFICATE OF DEATH

3462

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

Form 10-54

PLACE OF DEATH BALTIMORE		DECEASED MARTIN	
CITY OF BALTIMORE		AGE 40	
STREET BROADWAY		SEX M	
CITY BALTIMORE		DATE OF DEATH JAN 15 1956	
COUNTY BALTIMORE		HOURS 10:00 AM	
STATE MARYLAND		CAUSE OF DEATH HEART DISEASE	
CITY BALTIMORE		MANNER OF DEATH NATURAL	
COUNTY BALTIMORE		OCCUPATION MANAGER	
STATE MARYLAND		EDUCATION HIGH SCHOOL	
CITY BALTIMORE		RELIGION METHODIST	
COUNTY BALTIMORE		MARRIAGE MARRIED	
STATE MARYLAND		SPOUSE MRS. MARTIN	
CITY BALTIMORE		CHILDREN 2	
COUNTY BALTIMORE		PREVIOUS ILLNESS NONE	
STATE MARYLAND		TREATMENT HOSPITAL	
CITY BALTIMORE		PHYSICIAN DR. MARTIN	
COUNTY BALTIMORE		HOSPITAL BALTIMORE HOSPITAL	
STATE MARYLAND		DATE OF BURIAL JAN 16 1956	
CITY BALTIMORE		PLACE OF BURIAL BALTIMORE CEMETERY	
COUNTY BALTIMORE		FUNERAL HOME BALTIMORE FUNERAL HOME	
STATE MARYLAND		DATE OF INTERMENT JAN 16 1956	
CITY BALTIMORE		PLACE OF INTERMENT BALTIMORE CEMETERY	
COUNTY BALTIMORE		FUNERAL HOME BALTIMORE FUNERAL HOME	
STATE MARYLAND		DATE OF DEATH JAN 15 1956	
CITY BALTIMORE		PLACE OF DEATH BALTIMORE HOSPITAL	
COUNTY BALTIMORE		DECEASED MARTIN	
STATE MARYLAND		CITY BALTIMORE	
COUNTY BALTIMORE		AGE 40	
STATE MARYLAND		SEX M	
CITY BALTIMORE		DATE OF DEATH JAN 15 1956	
COUNTY BALTIMORE		HOURS 10:00 AM	
STATE MARYLAND		CAUSE OF DEATH HEART DISEASE	
CITY BALTIMORE		MANNER OF DEATH NATURAL	
COUNTY BALTIMORE		OCCUPATION MANAGER	
STATE MARYLAND		EDUCATION HIGH SCHOOL	
CITY BALTIMORE		RELIGION METHODIST	
COUNTY BALTIMORE		MARRIAGE MARRIED	
STATE MARYLAND		SPOUSE MRS. MARTIN	
CITY BALTIMORE		CHILDREN 2	
COUNTY BALTIMORE		PREVIOUS ILLNESS NONE	
STATE MARYLAND		TREATMENT HOSPITAL	
CITY BALTIMORE		PHYSICIAN DR. MARTIN	
COUNTY BALTIMORE		HOSPITAL BALTIMORE HOSPITAL	
STATE MARYLAND		DATE OF BURIAL JAN 16 1956	
CITY BALTIMORE		PLACE OF BURIAL BALTIMORE CEMETERY	
COUNTY BALTIMORE		FUNERAL HOME BALTIMORE FUNERAL HOME	
STATE MARYLAND		DATE OF INTERMENT JAN 16 1956	
CITY BALTIMORE		PLACE OF INTERMENT BALTIMORE CEMETERY	
COUNTY BALTIMORE		FUNERAL HOME BALTIMORE FUNERAL HOME	

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4487

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4488

CERTIFICATE OF DEATH

04495

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		LENGTH OF STAY (In this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dargan</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print) <u>SHERMAN</u> (First) <u>EDMOND</u> (Middle) <u>MYERS</u> (Last)				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 7, 1909</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Limestone Quarry Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Asher Myers</u>				14. MOTHER'S MAIDEN NAME <u>Florence Elizabeth Hoffmaster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>232-01-0041</u>		17. INFORMANT & ADDRESS <u>Margaret L. Myers</u> <u>RFD # 1, Harpers Ferry, W. Va.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1 <u>289.1</u> IMMEDIATE CAUSE (A) <u>Primary amyloid disease of liver, spleen</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>and heart</u>						<u>6 months.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1</u> , 19 <u>56</u> , to <u>2/15/56</u> , 19 <u></u> , that I last saw the deceased alive on <u>circa 2/30/56</u> , and that death occurred at <u>10:12A</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Shealy</u>				ADDRESS (Street, city, town, state) <u>Sharpsburg, Md.</u>		DATE SIGNED <u>4/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>Samples Manor Cemetery</u>		LOCATION (City, town, or county) (State) <u>Samples Manor, Md.</u>	
24. REC'D BY REGISTRAR <u>Apr. 14, 1956</u>		REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Cackles</u>		ADDRESS <u>Harpers Ferry West Va.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF CHURCH

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF BURIAL PLACE

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

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BUREAU V. S.

APR 17 1956

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At the time of death, the deceased was residing at the residence of the decedent, and was not in a hospital or institution. The death was not caused by a communicable disease, and was not a result of an accident or violence. The death was caused by natural causes, and was not a result of a self-inflicted wound or suicide. The death was not caused by a disease of the heart, lungs, or kidneys, and was not a result of a disease of the brain or nervous system. The death was not caused by a disease of the stomach or intestines, and was not a result of a disease of the liver or gallbladder. The death was not caused by a disease of the spleen or pancreas, and was not a result of a disease of the thyroid or parathyroid glands. The death was not caused by a disease of the endocrine system, and was not a result of a disease of the reproductive system. The death was not caused by a disease of the circulatory system, and was not a result of a disease of the respiratory system. The death was not caused by a disease of the digestive system, and was not a result of a disease of the excretory system. The death was not caused by a disease of the muscular system, and was not a result of a disease of the skeletal system. The death was not caused by a disease of the integumentary system, and was not a result of a disease of the sensory system. The death was not caused by a disease of the immune system, and was not a result of a disease of the nervous system. The death was not caused by a disease of the endocrine system, and was not a result of a disease of the reproductive system. The death was not caused by a disease of the circulatory system, and was not a result of a disease of the respiratory system. The death was not caused by a disease of the digestive system, and was not a result of a disease of the excretory system. The death was not caused by a disease of the muscular system, and was not a result of a disease of the skeletal system. The death was not caused by a disease of the integumentary system, and was not a result of a disease of the sensory system. The death was not caused by a disease of the immune system, and was not a result of a disease of the nervous system.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4489

CERTIFICATE OF DEATH

04496

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN <u>Life</u>				d. STREET ADDRESS <u>1717 Virginia Ave. Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Karen</u> Middle <u>Fouise</u> Last <u>Needy</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April - 19 - 1956</u>	
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>C. Edward Needy</u>				14. MOTHER'S MAIDEN NAME <u>Marglyn. Fleagle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>				16. SOCIAL SECURITY NO. <u>none.</u>			
17. INFORMANT <u>Mrs. Irene Needy</u>				Address <u>Bonnsboro Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.4 Congenital Valvular Heart Disease</u> DUE TO (b) <u>Immaturity</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>10 days (5 1/2 yrs)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/17/56</u> to <u>4/30/56</u> , that I last saw the deceased alive on <u>4/29/56</u> and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stearl Young</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>			
DATE SIGNED <u>4/30/56</u>							
PHYSICIAN'S NAME (Type) <u>STEARL YOUNG M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>April 30 1956</u>		<u>Bonnsboro Cemetery</u>		<u>Bonnsboro Wash. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home Bonnsboro Md</u>				24a. REC'D BY REGISTRAR <u>May 2, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2281335240

RECEIVED

4519

CERTIFICATE OF DEATH

Reg. Dist. No.

301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Va. b. COUNTY Wyoming Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Milton Middle Neely Last		4. DATE OF DEATH Month April Day 5 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27 1885
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Va. Railroad	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Neely		14. MOTHER'S MAIDEN NAME Rachael Wiley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 719-14-9031	
17. INFORMANT Mrs. Agnes E. Neely		Address 1128 Guy Avdatte Ave Mullens West Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary embolism DUE TO Femoral Thrombosis DUE TO Arteriosclerotic Plaque of Vessels DUE TO Arteriosclerotic Plaque of Vessels PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28 , 19 53 , to 5 April , 19 56 , that I last saw the deceased alive on April 28 , 19 56 , and that death occurred at 5:10 p.m. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Williamsport, Md. DATE SIGNED 5 April 56	
ACTUAL SIGNATURE Paul Haak		M.D. WILLIAMSPORT, MD.	
PHYSICIAN'S NAME (Type) PAUL HAAK, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 9-56	
22c. NAME OF CEMETERY OR CREMATORY Monte Vista		22d. LOCATION (City, town, or county) (State) Blue Field West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf		ADDRESS Williamsport, Md.	
24a. REC'D BY REGISTRAR April 6-56		24b. REGISTRAR'S SIGNATURE E. Lee M. Ebooy	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4490

CERTIFICATE OF DEATH

Reg. Dist. No.

04498

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. Pa. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2½ mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chambersburg	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 238 South Second St.,	
3. NAME OF DECEASED (Type or print) First Lula Middle M Last Nicklas		4. DATE OF DEATH Month 4 Day 27 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1886
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Dime Store	
11. BIRTHPLACE (State or foreign country) Franklin Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Nicklas		14. MOTHER'S MAIDEN NAME Maggie Hawbaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Elva R. Nicklas		Address Chambersburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular Accident 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 6 wks 10 yrs 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrene foot		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 13, 1956 , to Apr. 27, 1956 , that I last saw the deceased alive on Apr. 23, 1956 , and that death occurred at 1:12 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edw. W. Ditto III M.D.		ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown, Md.	
DATE SIGNED 4/28/56			
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.		217 W. Washington St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF may 1, 1956	22c. NAME OF CEMETERY OR CREMATORY Cedar Grove	22d. LOCATION (City, town, or county) (State) Chambersburg Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Paul Kraiss Sr.		ADDRESS Chambersburg, Pa.	
24a. REC'D BY REGISTRAR Apr. 30, 1956		24b. REGISTRAR'S SIGNATURE W. H. Powers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4491 CERTIFICATE OF DEATH Dr Hirshman\ 04500

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>711 George St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>WARREN</u> Last <u>OVELMAN</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 27 1881</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>		IF UNDER 24 HRS. Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pangborn Corp</u>		11. BIRTHPLACE (State or foreign country) <u>Emmitsburg Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Hiram Ovelman</u>				14. MOTHER'S MAIDEN NAME <u>Georgetta Singer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>314-09-416</u>		17. INFORMANT <u>Robert Ovelman</u> Address <u>Riverton Va. Box 35</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>490X</u> DUE TO (c) <u>490X</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X</u> DUE TO (b) <u>490X</u> DUE TO (c) <u>490X</u> DUE TO							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>11 30</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March 28, 1956</u> to <u>April 4, 1956</u> , that I last saw the deceased alive on <u>April 4, 1956</u> at <u>11 30 AM</u> , and that death occurred at <u>7 15 PM</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>				DATE SIGNED <u>April 9, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St. Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 7 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery near Detour Fred Co Md</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Apr 9, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles H. Baerwald</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. MARITAL STATUS		6. OCCUPATION		7. PLACE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH		11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE		19. SIGNATURE OF CLERK		20. SIGNATURE OF Scribe	
JAMES EARL RAY		Male		35		White		Single		Student		Memphis, Tenn.		Baltimore, Md.		April 4, 1968		10:00 PM		Shot		Suicide		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			
1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. MARITAL STATUS		6. OCCUPATION		7. PLACE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH		11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE		19. SIGNATURE OF CLERK		20. SIGNATURE OF Scribe	
JAMES EARL RAY		Male		35		White		Single		Student		Memphis, Tenn.		Baltimore, Md.		April 4, 1968		10:00 PM		Shot		Suicide		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			

BUREAU V. S.

APR 11 1956

RECEIVED

4492

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MORGAN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN		c. LENGTH OF STAY IN 1b 11 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERKLEY SPRINGS 85x-3 ✓		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 81 WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle LEROY Last PERRY JR.		4. DATE OF DEATH Month APRIL Day 17 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/56
9. AGE (In years last birthday) yrs. 12		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. COUNTRY OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY PERRY SR.		14. MOTHER'S MAIDEN NAME JEAN CAIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. HARRY PERRY SR.		Address BERKLEY SPRINGS W. VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Omphalocele - ruptured membrane DUE TO (c) Malrotation of intestines		INTERVAL BETWEEN ONSET AND DEATH 12 days 12 days 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/6/ , 19 56 , to 4/17/ , 19 56 , that I last saw the deceased alive on 4/17/56 , 19 56 , and that death occurred at 6 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Moran M.D.		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 4/18/56	
PHYSICIAN'S NAME (Type) JOHN A. MORAN M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/18/56	22c. NAME OF CEMETERY OR CREMATORY Greenway CEM.	22d. LOCATION (City, town, or county) (State) BERKLEY SPRINGS W. VA.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR 4/20/1956	24b. REGISTRAR'S SIGNATURE Cliff H. Bowers

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4493

CERTIFICATE OF DEATH

04502

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>7 days</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>11 W. Antietam Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>BELLE</u> Last <u>RAUTH</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1871</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Middlekauff</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Fiery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Miss. Grace Middlekauff Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Pseudomyxoma Peritonei</u> DUE TO (c) <u>Pseudomucinous cyst of ovary</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>15 yrs.</u> <u>16 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. p.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>41</u> , to <u>April 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>56</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D.				ADDRESS (Street, city or town, state) <u>214 N. Potomac St. Hagerstown, Md.</u> DATE SIGNED <u>4/13/56</u>			
PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lester Kasper</u> ADDRESS <u>Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>6/14/1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

MEDICAL CERTIFICATION

APR 17 1956

RECEIVED

BUREAU A. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4494 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04503

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro, Md.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>339 W. Antietam Street</u>				d. STREET ADDRESS <u>229 N. Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Amos</u> Last <u>Rensburg</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 56</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 18, 1903</u>		
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Amos A. Rensburg</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Sigler</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-1364</u>		17. INFORMANT <u>Mrs. Lelia Rensburg - 229 N. Main St.</u>				
Address <u>Boonsboro, Md.</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none</u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) - - -		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED <u>4-9-56</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro</u> <u>Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>East Funeral Home</u>				ADDRESS <u>Boonsboro, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 4-12-56</u>		
24b. REGISTRAR'S SIGNATURE <u>Chas A. Bowers</u>								

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARTLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 16

BUREAU V. S.

APR 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4495

CERTIFICATE OF DEATH

Dr E.W. Ditto III 04504

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>131 East Washington St</u>		d. STREET ADDRESS <u>131 East Washington St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>ELLSWORTH</u> Last <u>REMSBURG</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 7 1867</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Owner Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>near Sharpsburg Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Remsburg</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Huffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Milton E. Remsburg</u>		Address <u>Sharpsburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>20 yrs.</u> <u>25 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Benign prostatic hypertrophy - 12 yrs -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 12, 1954</u> , to <u>Apr 17, 1956</u> , that I last saw the deceased alive on <u>Apr 12, 1956</u> , and that death occurred at <u>5:57</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.		ADDRESS (Street, city or town, state) <u>217 W. Washington St.</u> DATE SIGNED <u>4/18/56</u>	
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>		<u>217 W. Washington St., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/20/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Apr 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Powers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4496

CERTIFICATE OF DEATH

Reg. Dist. No.

03545

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS 249 S. Locust St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alexander Middle R Last Rice		4. DATE OF DEATH Month 4 Day 28 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1900
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cab driver		10b. KIND OF BUSINESS OR INDUSTRY self owned	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Rice		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs. Maude Rice Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocarditis 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic hepatitis Adema - bronchitis DUE TO (c) emphysema		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 1 yr. 2 yrs upr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 14 , 19 37 , to April 28 , 19 56 , that I last saw the deceased alive on April 27, 1956 , and that death occurred at 6 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 4/28/56	
ACTUAL SIGNATURE Philip J. Hirshman M.D.			
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF May 1, 1956	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.		24a. REGISTAR May 1, 1956 24b. REGISTRAR'S SIGNATURE Frank Bowers	

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		MAY 3 1956	
AGE		SEX	
68 years		Male	
RACE		OCCUPATION	
White		Retired	
BIRTH DATE		BIRTH PLACE	
MAY 10 1887		BALTIMORE, MD.	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 15 1910		BALTIMORE, MD.	
EDUCATION		RELIGION	
High School		Roman Catholic	
PREVIOUS ILLNESS		CAUSE OF DEATH	
Heart Disease		Myocardial Infarction	
DATE OF ONSET		PLACE OF DEATH	
MAY 1 1956		Home	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME	
JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE		SIGNATURE	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE		DATE	
MAY 3 1956		MAY 3 1956	

BUREAU V. 8

MAY 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4497

CERTIFICATE OF DEATH

Reg. Dist. No.

04506
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 02 609 W. Franklin St.,		d. STREET ADDRESS 609 W. Franklin	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Richard		4. DATE OF DEATH Month 4 Day 13 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1885
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T Hamilton Feigley		14. MOTHER'S MAIDEN NAME Mary E. Mullenix	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT John P. Richard		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease & mitral stenosis & auricular fibrillation (c) ? Chronic glomerulonephritis			INTERVAL BETWEEN ONSET AND DEATH 30 min Unknown ? 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-12, 1938 , to 4-13, 1956 , that I last saw the deceased alive on 4-10, 1956 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Richard		ADDRESS (Street, city or town, state) 154 W. Washington St. - Hagerstown, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-56	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Traiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Apr. 16, 1956		24b. REGISTRAR'S SIGNATURE Chas. H. Powers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		1911		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		1956		BALTIMORE		MD		USA			
FAMILY PHYSICIAN		HOSPITAL		DATE OF EXAMINATION		DATE OF SIGNATURE		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			
J. H. HARRIS		BALTIMORE HOSPITAL		1956		1956		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS			
FAMILY PHYSICIAN		HOSPITAL		DATE OF EXAMINATION		DATE OF SIGNATURE		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			
J. H. HARRIS		BALTIMORE HOSPITAL		1956		1956		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS			

BUREAU V. S.

APR 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04507

4520

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 305

1. PLACE OF DEATH: COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u> TOWN <u>one town</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> TOWN <u>03</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Boonsboro MD R. 2</u>		STREET ADDRESS (If rural, give location) <u>122 - S. MULBERRY ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EMMA</u> (Middle) <u>K.</u> (Last) <u>RIDENOUR</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL - 27 - 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY - 16 - 1883</u>
9. AGE last birthday <u>72</u> yrs. <u>9</u> months <u>11</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARLEVILLE WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>BENJAMIN F. FOLTZ</u>	
14. MOTHER'S MAIDEN NAME <u>SAVILLA FAHNEY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>D. KELLER RIDENOUR 122 S. MULBERRY ST. BOONSBORO MD. R. 2</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) drowning

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 week

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>	(CITY OR TOWN) <u>Boonsboro</u>	(COUNTY) <u>Washington</u>	(STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4 - 27 - 56</u> <u>7:20 A.M.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Walked into farm pond</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Name or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>APRIL - 29 - 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>	LOCATION (City, town, or county) <u>Boonsboro</u>	(State) <u>MARYLAND</u>
DATE REC'D BY LOCAL REG. <u>April - 29 - 1956</u>	REGISTRAR'S SIGNATURE <u>John H. Baird</u>	24. FUNERAL DIRECTOR <u>BASI FUNERAL HOME</u>	ADDRESS <u>Boonsboro MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 2 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04508

4498

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>303 Vista Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Concetta</u> Middle <u>Anna</u> Last <u>Salamone</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 12, 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>22</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Cheada Province, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u> ✓	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nick Joseph Salamone</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>antennoschistic heart disease + acute</u> <u>420.0</u> DUE TO <u>fatal due to operation of April 4, 1956.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>acute mit</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/2/55</u> , 19 <u>55</u> , to <u>4/4/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/4/56</u> , 19 <u>56</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u>		ADDRESS (Street, city or town, state) <u>303 Vista Hagerstown, Md</u> DATE SIGNED <u>4/6/56</u>	
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		<u>136 North Potomac St., Hagerstown</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. Rager</u> ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>4/7/1956</u> 24b. REGISTRAR'S SIGNATURE <u>Bluff Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MD		USA	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
MARRIED		1910		BALTIMORE		MD		USA		BALTIMORE		1910		BALTIMORE		MD	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DEGREE		DATE		PLACE		CITY		STATE	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1900		BALTIMORE		BALTIMORE		MD	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION	
BALTIMORE		1910		BALTIMORE		MD		USA		BALTIMORE		1910		BALTIMORE		MD	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH	
HEART DISEASE		1925		BALTIMORE		MD		USA		BALTIMORE		1925		BALTIMORE		MD	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH	
NATURAL		1925		BALTIMORE		MD		USA		BALTIMORE		1925		BALTIMORE		MD	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
1925		BALTIMORE		BALTIMORE		MD		USA		1925		BALTIMORE		BALTIMORE		MD	
SIGNATURE OF DECEASED		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		1925		BALTIMORE		MD		USA		BALTIMORE		1925		BALTIMORE		MD	
SIGNATURE OF WITNESS		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		1925		BALTIMORE		MD		USA		BALTIMORE		1925		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		1925		BALTIMORE		MD		USA		BALTIMORE		1925		BALTIMORE		MD	
SIGNATURE OF CLERGYMAN		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		1925		BALTIMORE		MD		USA		BALTIMORE		1925		BALTIMORE		MD	
SIGNATURE OF BURIAL OFFICER		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		1925		BALTIMORE		MD		USA		BALTIMORE		1925		BALTIMORE		MD	

RECEIVED
BUREAU V. S.
APR 9 1925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4499 CERTIFICATE OF DEATH

04509

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 436 E. Franklin St.			
3. NAME OF DECEASED (Type or print) William Albertus Semler				4. DATE OF DEATH April 2 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1921	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lead Man		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John L. Semler				14. MOTHER'S MAIDEN NAME Mary M. Andrews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. War 11 219-14-7665		17. INFORMANT Address Mrs. D. N. Semler Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Glomerulonephritis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Hypertensive Cardiovascular Disease						INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 yrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 31, 1956 to April 2, 1956 , that I last saw the deceased alive on April 1, 1956 , and that death occurred at 6 P.M. from the causes and on the date stated above.						DATE SIGNED	
ACTUAL SIGNATURE Philip J. Hirshman		M.D.		ADDRESS (Street, city or town, state) 159 W. Washington St. Hagerstown Md. 21740		DATE SIGNED 4/4/56	
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hag. Md.				24a. REC'D BY REGISTRAR Apr. 5, 1956		24b. REGISTRAR'S SIGNATURE Charles Powers	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04511
Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIG POOL			c. LENGTH OF STAY IN lb LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIG POOL		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SHANKTOWN ROAD				d. STREET ADDRESS SHANKTOWN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle VICTOR Last SHAW				4. DATE OF DEATH Month 4 Day 7 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 3, 1913		9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY VICTOR PRODUCTS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL V. SHAW				14. MOTHER'S MAIDEN NAME NANCY E. KLINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-5754		17. INFORMANT Address SAMUEL V. SHAW BIG POOL, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhage from lungs DUE TO TB of lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 12 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells		EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-9-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/10/56		22c. NAME OF CEMETERY OR CREMATORY SHANKTOWN CEMETERY		22d. LOCATION (City, town, or county) (State) BIG POOL, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark				ADDRESS Clear Spring, Md.		24a. REC'D BY REGISTRAR DATE 4/10-56	
				24b. REGISTRAR'S SIGNATURE Joseph W. Mungy			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed the certificate, signed by the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4500 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04512

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>81 Washington County Hospital</u>				d. STREET ADDRESS <u>St. Paul Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Alberta</u> Last <u>Sigmund</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1879</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Cornelius Ridenour</u>			
14. MOTHER'S MAIDEN NAME <u>Amanda Brown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>L. Roy Sigmund, Husband - St. Paul St Boonsboro Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture lt. femur (Hemorrhage & shock)</u> DUE TO <u>Hypostatic pneumonia</u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Slipped and fell down the stair steps</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and fell down the stair steps</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>3:00</u> <u>XXX</u> P. M. <u>Apr. 22, 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>			
20f. (City or town) <u>Boonsboro,</u>		(County) <u>Wash</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>S. Robert Wells, M. D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-30-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-1-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro</u>			
22d. LOCATION (City, town, or county) <u>Boonsboro</u>		(State) <u>Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home</u>		ADDRESS <u>Boonsboro, Md.</u>		24a. REC'D BY REGISTRAR <u>May 2, 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 4 1956

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4501 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04513

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R # 3 Hagerstown, Md.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Mt. Etna Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances Elizabeth Smith</u>				4. DATE OF DEATH Month Day Year <u>April 25 19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1937</u>	
9. AGE (In years last birthday) <u>28 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Theater</u>		11. BIRTHPLACE (State or foreign country) <u>Atlanta, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Reeby Thompson</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>---</u> <u>356-34-3370</u>		17. INFORMANT Address <u>Mr. Robert A. Smith- Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple gun shot wounds into chest & abdomen (Hemorrhage & Shock) ,22 colt revolver</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>649X</u> <u>Pregnancy - Pre-mature delivery stillborn - 8 mos</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>(Cert. filed)</u> <u>Shot self in chest & abdomen</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>2:45</u> <u>4-23</u> <u>1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>Rural - Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4-25-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Atlanta Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 26/1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles H. Gowers</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES E. SMITH		45		M		W		APR 28 1956		BALTIMORE, MD	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		Carpenter		High School		Married		Heart Disease		Natural	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO MARRIAGE		DATE OF ENTRY INTO DEATH	
JAN 15 1911		BALTIMORE, MD		JAN 15 1911		JAN 15 1911		JAN 15 1911		JAN 15 1911	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
APR 28 1956		BALTIMORE, MD		APR 28 1956		BALTIMORE, MD		APR 28 1956		BALTIMORE, MD	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
APR 28 1956		BALTIMORE, MD		APR 28 1956		BALTIMORE, MD		APR 28 1956		BALTIMORE, MD	

RECEIVED
 APR 30 1956
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4502

CERTIFICATE OF DEATH

04514

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>22 North Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Claggett</u> Last <u>Strite</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-1905</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham C. Strite</u>				14. MOTHER'S MAIDEN NAME <u>Louella Claggett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Samuel C. Strite, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>323X</u> IMMEDIATE CAUSE (a) <u>Barbiturate Intoxication (Seconal)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>31 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-20</u> , 19 <u>43</u> , to <u>4-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-9</u> , 19 <u>56</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Horne, M.D.</u>				ADDRESS (Street, city or town, state) <u>154 W. Washington St. Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John H. Horne</u>				DATE SIGNED <u>4-11-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-11-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Rogers</u>				24a. REC'D BY REGISTRAR <u>4/12/1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4522

CERTIFICATE OF DEATH

04515
303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL CLEAR SPRING				c. LENGTH OF STAY IN 1b 8 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GATEWAY NURDING HOME				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHRISTOPHER Middle TRUMPOWER Last TRUMPOWER				4. DATE OF DEATH Month 4 Day 8 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 9 1880	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY TENANT FARMER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER TRUMPOWER				14. MOTHER'S MAIDEN NAME MALINDA TRAYER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-16-1368		17. INFORMANT Address MRS. LOUISE COMER CLEAR SPRING RT1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Sclerosis 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept 15, 19 55 to April 8, 19 56 that I last saw the deceased alive on April 7, 19 56 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Brewer M.D.				ADDRESS (Street, city or town, state) Clear Spring Md.		DATE SIGNED 4/9/56	
PHYSICIAN'S NAME (Type) David R. Brewer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/56		22c. NAME OF CEMETERY OR CREMATORY ST PAULS CEMETERY		22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ROWLAND FUNERAL HOME John F. Clark				ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR DATE Apr-13-56	
				24b. REGISTRAR'S SIGNATURE Leroy M. Fickler 1 Deputy			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. W. T. Layman

4523

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. STREET ADDRESS <u>204 Belleview Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>FLORENCE</u> Last <u>VANDRUFF</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Riley, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Osbourne</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Ruby Zeigler-204 Belleview Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriolar Nephrosclerosis</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>Questionable</u> <u>2 Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Basilar Bronchopneumonia - 5 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2, 19 56</u> , to <u>April 7, 19 56</u> , that I last saw the deceased alive on <u>April 6, 19 56</u> , and that death occurred at <u>5:27A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>April 21, 1956</u>			
ACTUAL SIGNATURE <u>W. T. Layman</u> M.D.		PHYSICIAN'S NAME (Type) <u>W. T. Layman, M. D.</u> <u>5 Public Sq., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grand View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Riley, Riley Co. Kansas</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Goffman-Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Apr. 9, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. RACE [REDACTED]		9. RELIGION [REDACTED]		10. EDUCATION [REDACTED]		11. SOCIAL SECURITY NUMBER [REDACTED]		12. MOTHER'S MAIDEN NAME [REDACTED]	
13. DATE OF DEATH [REDACTED]		14. TIME OF DEATH [REDACTED]		15. PLACE OF DEATH [REDACTED]		16. CAUSE OF DEATH [REDACTED]		17. MANNER OF DEATH [REDACTED]		18. SIGNATURE OF DECEASED [REDACTED]	
19. SIGNATURE OF WITNESS [REDACTED]		20. SIGNATURE OF PHYSICIAN [REDACTED]		21. SIGNATURE OF CORONER [REDACTED]		22. SIGNATURE OF BURIAL OFFICIAL [REDACTED]		23. SIGNATURE OF VENDOR [REDACTED]		24. SIGNATURE OF OTHER [REDACTED]	

BUREAU V. S.

APR 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4524 CERTIFICATE OF DEATH

04517

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS RFD #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hattie Middle May Last Walter		4. DATE OF DEATH Month April Day 26 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1885
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY grocery store	
11. BIRTHPLACE (State or foreign country) Leitersburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Miller		14. MOTHER'S MAIDEN NAME Alice Garver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-34-0283	
17. INFORMANT Harrison F. Walter, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes Mellitus DUE TO Carcinoma of Pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis - Sclerosis INTERVAL BETWEEN ONSET AND DEATH 3 wks 15 yrs 7 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1956 to April 26, 1956 that I last saw the deceased alive on April 26, 1956 , and that death occurred at 8:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 7/27/56			
ACTUAL SIGNATURE G. A. Kohler		M.D. Smithsburg, Md.	
PHYSICIAN'S NAME (Type) G. A. Kohler, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-28-56	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR May 1, 1956	
		24b. REGISTRAR'S SIGNATURE Chas. Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4505 CERTIFICATE OF DEATH

04518

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna Middle Florence Last Waltz				4. DATE OF DEATH Month April Day 22 , Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82		IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) general work				10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Cavetown, Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Martin L. Waltz				14. MOTHER'S MAIDEN NAME Margaret E. Dayhoff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. - -		17. INFORMANT Address Tyson R. Waltz, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease with 420.0 DUE TO Myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial failure DUE TO (c) Myocardial failure							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 yrs +							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1946 , to 22 Apr 1956 , that I last saw the deceased alive on 26 apr 1956 , and that death occurred at 4:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby				ADDRESS (Street, city or town, state) 2301 Potomac DATE SIGNED 23 Apr 56			
PHYSICIAN'S NAME (Type) F. F. Lusby				M.D. Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-24-56		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				24a. REC'D BY REGISTRAR 26 1956 24b. REGISTRAR'S SIGNATURE Chas. H. Bowers			

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. RACE [REDACTED]</p>	
<p>5. DATE OF BIRTH [REDACTED]</p>		<p>6. PLACE OF BIRTH [REDACTED]</p>	
<p>7. DATE OF DEATH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>	
<p>9. CAUSE OF DEATH [REDACTED]</p>		<p>10. MANNER OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF DECEASED [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>13. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>14. SIGNATURE OF CORONER [REDACTED]</p>	
<p>15. SIGNATURE OF JURY [REDACTED]</p>		<p>16. SIGNATURE OF JUDGE [REDACTED]</p>	

RECEIVED
 APR 26 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Packer

4506

CERTIFICATE OF DEATH

Reg. Dist. No.

04519

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>3 hrs.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>277 South Potomac St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE EMMA WILEY</u>				4. DATE OF DEATH Month Day Year <u>April 2 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1888</u>	9. AGE (In years last birthday) yrs. <u>67</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Binder - Hag. Book Binding</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William S. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-7039</u>		17. INFORMANT Address <u>Mr. Charles R. Wiley-277 S. Potomac St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>Myocardial infarct - healed and recent</u> <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac hypertrophy, benign nephrosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 months</u> <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 2</u> , 19 <u>56</u> , to <u>April 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 2</u> , 19 <u>56</u> , and that death occurred at <u>12:40</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>L. L. Packer Jr</u> M.D. _____							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>Dec 5/1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

APR 9 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

302

4507

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1969 Jefferson Blvd.</u>		e. STREET ADDRESS <u>1969 Jefferson Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>M.</u> Last <u>Wolfe</u>		4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/8/1878</u>
9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel Himes</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Willie B. Wolfe, Myersville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. si. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 18, 1956</u> , to <u>April 19, 1956</u> , that I last saw the deceased alive on <u>April 19, 1956</u> , and that death occurred at <u>4 A</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>G. A. Kohler</u> M.D.		DATE SIGNED <u>April 30, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Dr. G. A. Kohler</u>		<u>Smithburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/22/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel U.B. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>		24a. REC'D BY REGISTRAR <u>Apr. 24, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Blatt Beavers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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